



Virginia Department of Behavioral Health and Developmental Services
RENEWAL PROVIDER APPLICATION FOR LICENSING

SECTION 1: Applicant Renewal Information: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Organization Name: _____ License # _____

Mailing Address _____

City: _____ County _____ State: _____

Zip: _____ Phone: () _____

CEO or CAO: _____ Phone: () _____

Fax Number: () _____ Email: _____

****Please review the “licensed as” statement for accuracy in the descriptions of services. If any are inconsistent with the actual service, please note the discrepancy on the license.**

SECTION 2: Service Renewal Information: Please list the license numbers you are applying for renewal:

1. _____ - _____ - _____

9. _____ - _____ - _____

2. _____ - _____ - _____

10. _____ - _____ - _____

3. _____ - _____ - _____

11. _____ - _____ - _____

4. _____ - _____ - _____

12. _____ - _____ - _____

5. _____ - _____ - _____

13. _____ - _____ - _____

6. _____ - _____ - _____

14. _____ - _____ - _____

7. _____ - _____ - _____

15. _____ - _____ - _____

8. _____ - _____ - _____

16. _____ - _____ - _____

SECTION 3: Service Close Information: Please list the license numbers you are choosing **NOT TO RENEW** and are surrendering:

1. _____ - _____ - _____

4. _____ - _____ - _____

2. _____ - _____ - _____

5. _____ - _____ - _____

3. _____ - _____ - _____

6. _____ - _____ - _____

SECTION 4: Service Change Information: PLEASE LIST CHANGES ONLY:

1. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone: ()** _____
Fax Number: _____ **Location E-mail:** _____
Directions: _____

2. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone: ()** _____
Fax Number: _____ **Location Email:** _____
Directions: _____

3. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone: ()** _____
Fax Number: _____ **Location Email:** _____
Directions: _____

4. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone: ()** _____
Fax Number: _____ **Location Email:** _____
Directions: _____

5. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone: ()** _____
Fax Number: _____ **Location Email:** _____
Directions: _____

Note: If there are additional locations, please photocopy additional sheets as needed.

SECTION 5. CERTIFICATE OF APPLICATION:

This Certificate of Application is to be read and signed by the applicant. The person signing below must be the individual applicant in the case of a proprietorship or partnership, or the chairperson or equivalent officer in the case of a corporation or other association, or the person charged with the administration of the service provided by the appointing authority in the case of a governmental agency.

I am in receipt of and have read the applicable rules and regulations for licensing. It is my intent to comply with the statutes and regulations and to remain in compliance, if licensed.

I grant permission to authorized agents of the Department of Behavioral Health and Developmental Services to make necessary investigations into this application or complaints received. I understand that unannounced visits will be made to determine continued compliance with regulations.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

IT IS MY INTENT TO: (a) COMPLY WITH ALL APPLICABLE STATUTES AND (b) TO MAINTAIN COMPLIANCE WITH ALL APPLICABLE REGULATIONS

Signature of Applicant: _____ Date: _____

Title: _____

RENEWAL FEE:

Providers of CHILDREN'S RESIDENTIAL SERVICES only must submit with the renewal application a \$100.00 renewal fee. The business check or a money order should be made payable to the "Treasurer of Virginia". Personal checks or cash are not accepted

RETURN ADDRESS:

*If you have any questions concerning the application, please contact this office at (804) 786-1747.
Please return this application within 30 days of receipt to:*

**The Office of Licensing
Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797
Website: <http://www@dbhds.virginia.gov>**

Please note: Failure to return may delay the renewal of this provider license and services.